

REGISTRATION OF RADIATION MACHINE FACILITIES

The Department of Human Services does not discriminate on the basis of disability, race, color, creed, gender, age or national origin in admission to, access to, or operations of its programs, services or activities, or its hiring or employment practices. This information is available in alternate formats upon request

FACILITY

NAME: _____

ADDRESS: _____

TELEPHONE: () _____

RADIATION SAFETY PERSON (RSO)

NAME: _____

ADDRESS: _____

TELEPHONE: () _____

RADIATION MACHINE

MANUFACTURER: _____

MODEL NUMBER: _____

CONSOLE SERIAL: _____

TUBE SERIAL: _____

RATING - MAX. kVp: _____

MAX. mA: _____

SUPPLIER: _____

INSTALLER: _____

SERVICE AGENT: _____

[1] STATIONARY

[2] PORTABLE

[3] MOBILE

GEOG. LOCATION: _____

ADMINISTRATOR/MACHINE OWNER

NAME: _____

ADDRESS: _____

TELEPHONE: () _____

SIGNATURE: _____

Date Form Completed: _____

TYPE OF PRACTICE

- | | |
|------------------|-------------------------------|
| [1] Medical | [7] Schools |
| [2] Dental | [8] Hospital |
| [3] Podiatric | [9] Mammographic |
| [4] Chiropractic | [10] Colleges |
| [5] Industrial | [11] OTHER |
| [6] Veterinary | [12] State owned and operated |

FACILITY SUPERVISOR

NAME: _____

SIGNATURE: _____

RADIATION MACHINE

TYPE OF MACHINE:

- [1] Dental
- [2] Radiographic
- [3] Fluoroscopic
- [4] Intensifier
- [5] Computerized Tomography
- [6] Cephalometric
- [7] Panoraphic
- [8] Combination Fluoro - Radiographic
- [9] Therapy
- [10] Industrial
- [11] OTHER
- [12] Mammographic
- [13] Bone Densitometry

ROOM # _____

INSPECTION

DATE OF LAST INSPECTION: _____

INSPECTED BY WHOM: _____

[] NEVER INSPECTED

OFFICE USE ONLY:

FACILITY ID #: _____

RECEIPT #: _____

AMOUNT: _____

REGISTRATION #: _____

EXPIRATION DATE: _____

TOTAL # OF TUBES: _____